TennCare CHOICES
in Long-Term Care Program

Nursing Facilities
Webinar Update

February 23, 2010

TennCare

ENROLLMENT

- Enrollment processes will be handled by the Choices Enrollment Unit (current Claims Unit).

Current Staff:

- Rosa Bell – 615-507-6983
- Jackie Binkley – 615-507-6989
- Sonya Capps – 615-507-6988
- Kim Carroll – 615- 507-6027
- Barbara Fahey – 615-507-6995
- Deborah Matlock – 615-507-6945
- Victoria White – 615-507-6993
- Kim Williams – 615-507-6998

Choices Conversion

- Using the current data within the TennCare interChange system, Middle TN enrollees currently receiving either nursing facility or HCBS services, have been systematically converted to the appropriate Choices enrollment a with March 1, 2010 effective date.

Choices Claims

- Claims with date of service beginning March 1, 2010, must be submitted to the enrollee's assigned MCO (Managed Care Organization).
- Each MCO has their own electronic claim submission system that accepts HIPAA compliant UB04 claim format data and has the capability to accept batch claim submissions (837I).
- **PLEASE NOTE**: Enrollments into Choices, for Middle Tennessee are based on the enrollee's county of residence. Therefore, it is possible for a Medicaid enrollee to not be enrolled into Choices, even though they reside in the Middle Tennessee area, because of having an East or West Tennessee county code. Cases such as this are considered Non-Choices and will remain as Medicaid fee-for-service until such time that their county is changed to Middle Tennessee or when Choices is statewide.

Fee For Service Claims (FFS)

- The Tennessee Anytime web claim submission system will be the method in which to submit claims with dates of service before March 1, 2010.
- Medicare Crossover claims will continue to be paid by the Bureau of TennCare as FFS claims, and going forward, should be submitted in the same manner in which they are today. The current Claims Unit will continue to be the contact for Medicare Crossover claim issues.
- System claim edits are in place within the Bureau of TennCare's system that will deny FFS claims for Choices members (Middle TN only), containing dates of service beginning with March 1, 2010.

Choices Enrollment Groups

- Group 1A = CH1A – ICF
- Group 1B = CH1B – SNF
- Group 2A = CH2A – HCBS
- Group 2B = CH2B – HCBS for use only after enrollment cap is met for recipients transitioning from a nursing facility to the community.
- Group 2C = CH2C – HCBS – Immediate Eligibility (must be under enrollment target to enroll in this category)
- Group 2D = CH2D – HCBS for use to transition active SSI only, after the enrollment target is met, as a cost effective alternative.

ENROLLMENT

- The Enrollment Unit will manage all Choices enrollments, transitions and dis-enrollments.
- The TPAES system will be utilized to handle most all Choices **enrollments** and **transitions**. Paper forms will only be utilized in the event of system failure that endures beyond normal business hours of one day.
- **PLEASE NOTE**: **An approved PAE does not mean that an applicant will be enrolled in Choices.**

Enrollment Processes

- Once a Choices PAE is approved and applicable notices are sent, TPAES will auto-generate an enrollment form to the enrollment queue. The Enrollment Unit will perform a "pre-screening" of the enrollment form to determine:
  - Can the enrollment be approved?
    - ❑ No. Enrollment is denied and appropriate notices containing appeal rights are sent.
    - ❑ Yes. Validate if the applicant has current Medicaid in an appropriate category.

- If the applicant does not have Medicaid, the Enrollment Unit will notify the appropriate SPOE (Single Point of Entry), as well as auto-generate the enrollment form to DHS (Department of Human Services). DHS will use the Enrollment Form as a quasi 2350 form. No paper 2350's will be required for Middle TN nursing facilities; only for facilities in East and West TN will submit paper 2350 forms.
- If the applicant has Medicaid, the Enrollment Unit will add the PAE to TennCare's interChange system. This ensures notification to the applicant's MCO (Managed Care Organization) that an applicant has an approved PAE. The enrollment form will then be auto-generated to DHS for calculation or re-calculation of patient liability.

TennCare

Enrollment Processes

- Choices levels of care will be indicated in the interchange system on the Choices LOC window as “10” for Choices PAE (ICF and HCBS) and “11” for Choices skilled PAE (SNF).
- **Please note**: If Medicaid application process is facilitated by AAADs (Area Agency on Aging and Disability), also known as the SPOE, the interview process will be waived and; DHS will make eligibility decision within no more than 10 business of receipt of days of complete application and required documentation.

Enrollment Processes

- Once the DHS caseworker determines an applicant's status, to either approve or deny Medicaid, calculates patient liability for approvals (quasi 2362 form), along with effective dates, the enrollment form will be auto-generated back to the Enrollment Unit's TPAES queue.
- The Enrollment Unit will perform the second enrollment review.
  - Can the enrollment be approved?
    - ❑No. Enrollment is denied and appropriate notices containing appeal rights are sent.
    - ❑Yes. Within three days of receipt of all pertinent documents, the Enrollment Unit will enter the appropriate enrollment group into TennCare's interChange system.

TENNCARE

Enrollment Processes

- In order to enroll in Group 1, the Enrollment Unit must have an admit date. If no admit date is indicated on the Enrollment Form, an “Admit Date Reminder Notice” will be generated to the NF or the submitter. These notices will be tracked in the “Admit Date Reminder Notice” queue for Enrollment Unit staff to track.
- Enrollments entered into TennCare’s interChange system will auto- generate a “Welcome to Choices” notice to the enrollee. In addition, an overnight electronic process will transmit the enrollment data to the appropriate MCO.
- The submitter will be notified via TPAES, once an Enrollment has been approved or denied.

Enrollment Processes

Reasons for enrollment denial (but not limited to):

- Eligible for Medicaid only – asset transfer penalty for NF vendor payments
- Medicaid application denied
- Not eligible for Medicaid in SSI or Institutional Category (Group 2 only)
- Does not meet level of care (no approved PAE)
- Does not meet target criteria; Elderly/Physically Disabled (Group 2 only)
- Safety, Safety and Cost Neutrality (Group 2 only)
- Enrollment target met and does not meet specified exceptions for NF (Nursing Facility) transitions or CEA (Cost Effective Alternative)

Enrollment Processes

- The Enrollment Unit will monitor all enrollment queues to ensure all processes are completed in a timely manner.
- Enrollment denial appeals will be handled with the Division of Long Term Care.

Dis-Enrollments

- Dis-enrollments can be voluntary or involuntary.

o Voluntary dis-enrollments require the enrollee or enrollee's designee to sign a "Voluntary Dis-Enrollment" form

o Involuntary dis-enrollments can occur for more than several reasons, which include but are not limited to:

  - No longer meets level of care (Groups 1 and 2)
  - Cost neutrality exceeded (Group 2 only)
  - No longer qualifies for Medicaid (Groups 1 and 2)
  - Enrollee not paying patient liability (Groups 1 and 2)
  - Safety needs can no longer be met (Group 2 only)
  - No longer receiving services (Groups 1 and 2)

Transfer PAE Forms

- There will be no Transfer PAE forms for Choices. Transfers will be handled by the MCO's.

Dis-Enrollments

- The Enrollment Unit will receive both Voluntary and Involuntary dis-enrollments. The appropriate dates and codes will be entered into TennCare's interChange system and appropriate notices will be auto-generated according to the dis-enrollment reason entered.
- Voluntary Dis-Enrollments have no appeal rights.
- Appeals associated with Involuntary Dis-Enrollments will be handled within the Long Term Care Division of the TennCare Bureau.

Single Point of Entry

- One access point for new Medicaid applicants seeking access to LTC services (HCBS and Nursing Facility):
  - Education and Outreach
  - Information and Referral
  - Screening and Assessment
  - Facilitate eligibility and enrollment

Single Point of Entry

- Area Agencies on Aging and Disability (AAADs) If Medicaid application process is facilitated by AAADs, the interview process will be waived and;

  - DHS will make eligibility decision within no more than 10 business of receipt of days of complete application and required documentation.

NFs may continue to submit PASRRs, PAEs, and Medicaid applications as always.

Single Point of Entry

- The requirement for 30 days continuous confinement will be satisfied upon PAE approval, for both nursing facilities and HCBS. (HCBS requires approval for immediate enrollment to qualify.)

  - Effective date of eligibility cannot precede date of admission to the NF or ICF/MR.

Member Choice

- Members eligible for LTC choose between NF and HCBS
  (even if HCBS would be more cost-effective)
  - Members in HCBS must be able to have needs safely met in the community at a cost that does not exceed NF care
- Members will be able to choose their Nursing Facility provider
  - Contracted with the MCO
  - Able to admit the member
  - Able to provide the needed services

Additional Benefits Covered Under CHOICES

- New Community Based Residential Alternatives
  - Critical Adult Care Homes
    - 24-hour residential care in a homelike environment to no more than 5 elderly or disabled adults
    - Level II – Specialized and/or Skilled Services:
      - Ventilator Care: Requires a licensed professional on site at all times (ACH provider, resident manager, or substitute caregiver)—physician, nurse practitioner, registered nurse, or respiratory therapist trained and experienced in the care of ventilator dependent residents

        Per diem rate will be $450 per resident, rate includes room and board charges

New Community Based Residential Alternatives (cont'd)

- **Critical Adult Care Homes for Adults with Traumatic Brain Injury**

  - Covers the provision of personal care, household and living skills assistance or training, supervision and specialized behavior services, as needed pursuant to each resident's POC plan of care.

  - Licensed professional on site at all times (ACH provider, resident manager, or substitute caregiver)—physician, nurse practitioner, registered nurse, licensed rehabilitation professional or licensed mental health professional trained and experienced in the care and rehabilitation of residents with TBI (pending technical correction in the statute)

  - Per diem rate will be $217 per resident, includes R&B

- Continuum Model – Allows members to age in place

- Rules expected to be promulgated soon.

TennCare

Care Coordination in CHOICES

- Comprehensive, continuous, holistic, and person-centered approach to care coordination
  - Help the member maintain or improve physical or behavioral health status or functional abilities
  - Maximize member independence
  - Ensure the member's health, safety and welfare
  - Delay or prevent the need for institutional placement
- Integrated model of coordination of care –medical as well as social
- Addresses physical, behavioral, functional (ADL) and psychosocial needs
- Coordinates ALL Medicaid services for the elderly and disabled – physical, behavioral and long term care

Care Coordination for Nursing Facility Residents

- NF develops Plan of Care
- NF POC process proceeds based on current federal requirements
- MCO may supplement NF plan of care with additional targeted strategies **to be implemented by the MCO** related to improving health, functional, or quality of life outcomes or to increase and/or maintain functional abilities
- Focus on better management of chronic conditions and **coordination of services outside the scope of the NF benefit**
- MCO POC supplements are medical records; may or may not be contained in the NF medical record
- Should not impact survey process

Care Coordination for Nursing Facility Residents

MCOs must also:

- Assess member potential and interest for transition to community (based on member choice)
- Complete transition screening, assessment and planning processes as applicable

- Care Coordination Contact Requirements
  - Quarterly meetings
  - Semi-annual member face-to-face contact

What happens when CHOICES is implemented?

- Members receiving NF care will continue to qualify for and receive NF care
- Members will be able to stay in the NF where they currently reside, so long as the NF meets CMS conditions of participation
- Members are transitioned into CHOICES
  - **LTC Services are provided via CHOICES**
  - **LTC Services are NO LONGER provided via the current fee-for-service system**
  - **Payment will come from the MCOs**

TennCare

The Linton Order under CHOICES

The Order has <u>not</u> changed.

- If a facility contracts with *one or more* MCOs as a participating provider in that MCO's network, they are a Medicaid NF, and are subject to all applicable Linton requirements.
- If a facility elects not to contract with *any* of the TennCare MCOs as a participating provider, they have elected to withdraw from participation in the Medicaid program.
  - If such facility elects to continue receiving Medicaid payment for existing residents, they are subject to all aspects of the Linton Order pertaining to such residents.

The Linton Order under CHOICES

- Medicaid NFs (participating with one or more MCOs) must admit on a first come, first served basis, regardless of payer source, expect as specified in the Order (e.g., medical need)

- MCOs cannot "place" a person in a Medicaid (or participating) NF ahead of persons on the waiting list (except as specified in the Order)

The Linton Order under CHOICES

- Residents cannot be involuntarily discharged from a Medicaid facility when the source of payment changes (Medicare to Medicaid), due to
  - a reduction in the level of NF reimbursement (i.e., Level II to Level I), or :
  - because the facility opts not to contract with the MCO as a participating provider in the MCO's network

  (as long as the facility elects to continue to receive Medicaid payments for existing residents, including existing residents who may become Medicaid eligible).

The Linton Order under CHOICES

- Facilities that have withdrawn from Medicaid participation but have Medicaid residents in the facilities must have a modified contract (called a case agreement) with the MCOs to receive payment for current Medicaid residents (payment will be made by the MCO); the NF will be a non-participating provider.

- Facilities that have withdrawn from Medicaid participation that continue to accept payment for Medicaid residents in the facilities will be reimbursed at non-participating rates (80% of lowest rate for any facility after expiration of the 30-day continuity of care period)

Critical Incident Management and Reporting

- Critical incident management and reporting processes for nursing facility residents will be managed through the existing unusual incident process with the Tennessee Department of Health, Division of Health Care Facilities.
- Critical incident management and reporting requirements specified under CHOICES are applicable only to Home and Community Based Services (HCBS) providers (except for Abuse/ Neglect reporting).

When Nursing Facilities are required to Notify MCOs regarding Abuse

- Nursing facilities must notify the MCO when there is any reported instance of abuse or neglect
- MCOs will not duplicate investigative processes in place at Adult Protective Services or by HCF, but need to be advised of the issue for Care Coordination purposes

Background Check Requirements

- Nursing facilities are obligated to meet background check requirements, as specified in state law and are not subject to new or additional requirements under CHOICES.
- Fingerprints or detective reports are only required for Consumer Direction workers.

Enhanced Nursing Facility Rates

- In addition to Level I and Level II NF rates (established by the Comptroller's Office), there will be 3 enhanced NF rates:
  - Vent Weaning (VW)
  - Chronic Ventilator Care (CV)
  - Tracheal Suctioning (TS)

- Medical necessity criteria for VW NF services will be managed by the MCO:
  - determine if services are medically necessary
  - authorize the services for the appropriate period of time

Enhanced Nursing Facility Rates

- Medical necessity - PAE eligibility criteria for the CV and TS rates will be handled by the LTC PAE unit.

- Eligibility criteria for CV reimbursement will be based on coverage criteria for PDN – ventilator-dependent at least 12 hrs/ day with an invasive patient end of the circuit

- Eligibility criteria for TS approved only for persons with a functioning tracheostomy who require suctioning through the tracheostomy, at a minimum, multiple times per 8-hour shift.
  - **Suctioning of the nasal or oral cavity does not qualify**

Enhanced Nursing Facility Rates

- An MCO may authorize, based on medical necessity criteria, short-term payment at the TS rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention.

- Medical necessity criteria and authorization of the TS rate for such short-term purposes will be managed by the MCO.

- Authorization of the TS rate only for this short-term post-weaning intensive respiratory intervention shall be made only to NFs that meet standards of care for the delivery of ventilator services.

TennCare

Enhanced Nursing Facility Rates

- Rates:
  - $750 per day for VW
  - $600 per day for CV
  - $400 per day for TS (including post-ventilator weaning)

- These are stand-alone rates and NOT an add-on to the established NF per diem.

Enhanced Nursing Facility Rates

- Reimbursement of the VW and CV rates will be made only for NFs that meet standards of care for delivery of ventilator services.

- Standards of care for the delivery of ventilator services are applicable for TS rate only if the rate is authorized by the MCO on a short-term basis post-weaning. Otherwise, a NF authorized to deliver services at the TS rate must ensure the availability of necessary equipment, supplies, and appropriately trained and licensed nurses or licensed respiratory therapists to perform the specified tasks.

Enhanced Nursing Facility Rates

A facility that provides ventilator services shall meet or exceed the the following minimum standards:

- A licensed respiratory care practitioner as defined by Tennessee Code Annotated Section 63-27-102(7), shall be on site twenty four (24) hours per day, seven (7) days per week to provide:
  - ventilator care;
  - administration of medical gases;
  - administration of aerosol medications; and
  - diagnostic testing and monitoring of life support systems.

- The facility shall ensure that an appropriate individualized plan of care is prepared for each patient requiring ventilator services. with input and participation from a pulmonologist or a physician with experience in ventilator care.

- The facility shall establish admissions criteria to ensure the medical stability of ventilator-dependent patients prior to transfer from an acute care setting.

TennCare

Enhanced Nursing Facility Rates

- Arterial Blood Gas (ABG) shall be readily available in order to document the patient's acid base status and/or End Tidal Carbon Dioxide (etCO2) and continuous pulse oximetry measurements should be performed in lieu of ABG studies.

- An audible, external alarm system shall be located outside of each ventilator-dependent patient's room for the purpose of alerting caregivers of patient disconnection, ventilator disconnection or ventilator failure.

- Ventilator equipment shall be connected to electrical outlets connected to back-up generator power.

- Ventilators shall be equipped with battery back-up systems.

- The facility shall be equipped to employ the use of current ventilator technology consistent with meeting patients' needs for mobility and comfort.

TennCare

New Length of Stay Requirement on PAE

- **Anticipated Length of Stay, must be documented on the PAE itself.**
- **The PAE must indicate the anticipated length of stay in order to determine whether the person is considered to be "permanently institutionalized." This is to ensure compliance with federal estate recovery law for persons admitted under age 55.**
- **We will approve the PAE only up to the anticipated length of stay. Open ended PAEs will be authorized only when the stay is anticipated to be permanent.**

TennCare

New Length of Stay Requirement on PAE

- **PAE must indicate when discharge is expected (if discharge expected within 6 months we will not - approve an open-ended PAE)**

  - PAE approval will not be longer in duration than the anticipated length of stay

- **If discharge was expected but does not occur, a new PAE must be submitted.**

TennCare

Contracting with the MCOs

- MCOs required to contract with all current Medicaid certified Nursing Facilities for the first three years of CHOICES
  - Must meet CMS conditions of participation
  - MCOs may not terminate Provider Agreement during this time as long as NF continues to meet conditions of participation
  - Must be licensed by the State
- **<u>Liability Insurance exception for Nursing Facilities</u>**

- Nursing Facilities who contract to provide HCBS services are not required to carry additional liability insurance as a condition of providing HCBS services

Credentialing

- Part of the Contracting process
  - ALL providers must be credentialed in order to participate in the MCO network
  - Process by which MCO verifies that providers meet all applicable state and federal provider qualifications
  - Must be conducted in accordance with National Committee for Quality Assurance (NCQA) guidelines
- Specifics for Nursing Facility Providers
  - Providers who meet CMS conditions of participation may be included in the MCO network
  - Verification of existing Medicaid provider information
  - MCOs will work with NF to streamline the process as much as possible

What if you don't want to contract with an MCO?

- Nursing Facilities are NOT obligated to contract with each MCO

  BUT……
- Existing Medicaid fee-for-service system will no longer exist once CHOICES is implemented
- Non-contracted facilities will be reimbursed by MCO for services provided to existing Medicaid/LTC members – but at a lower payment rate than if contracted with the MCO
  - **80% of the lowest rate paid by the MCO to participating network providers for the same service (as set forth in TennCare Rule)**
- MCOs will seek to admit all new residents to contracted facilities

TENNCARE

Approval of Subcontracts

- MCOs are required by TennCare to assure that contracted providers do not enter into subcontracts for any of the services covered under their provider agreement without the prior written approval of the MCO.
    - Pertains only to the delivery of services under the provider agreement for which Medicaid payment will be made (does not include contracts such as vending machine agreements or other supportive services)

Authorization of NF Services

- Immediate authorization of Nursing Facility services for CHOICES members
  - In accordance with level of nursing facility services approved by TennCare, i.e., TennCare level of care reimbursement) decision drives prior authorization of NF services
  - MCO cannot authorize a lesser level or duration of services than approved by TennCare
  - MCOs will conduct concurrent review of Level II services and may initiate a request to TennCare to reduce when appropriate

NF Role in Level of Care Eligibility

- NFs may continue to complete and submit PAEs to TennCare (also hospitals, SPOEs, MCOs)
  - Level I
    - Nursing Facility Care
  - Level II
    - Skilled Nursing Facility (SNF) Care
    - Enhanced Rates
- TennCare will continue to determine level of care (reimbursement)

CHOICES NF Provider Billing and Reimbursement

- Electronic Web-based Claims Submission
  - MCO training on understanding and using billing and claims processing systems
  - Training and technical assistance will be provided before, during, and after CHOICES implementation

- Enhanced MCO Prompt Pay Requirements
  - 90% of clean electronic claims within 14 days
  - 99.5% of clean electronic claims within 21 days

- TennCare will set the rates for LTC services
  - Reimbursement in accordance with facility's per diem rate established by the Office of the Comptroller based on submitted cost reports
  - In the future, transition to acuity-based rates

TENNCARE

Using In-Network Physicians and Hospitals

- TennCare Rules specifically exclude from coverage “[n]on-emergency services that are ordered or furnished by an out-of-network provider…
- If the physician currently serving residents in the facility is not a contract provider, s/he may be able to enroll as a contract provider.

TENNCARE

QUESTIONS